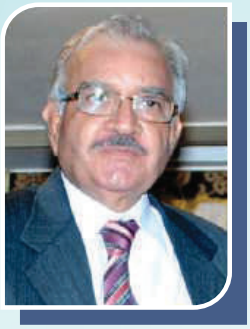
With This Issue "DOs AND DON'Ts" By Dr. Lalit Kapoor, Completes an Unprecedented 20 Years



DOs AND DON'Ts

RETAINED SURGICAL MOP- MEDICO-LEGAL CONSEQUENCES

Dr. Lalit Kapoor

One of the most demoralizing and frustrating medico-legal problems to be saddled with is one arising out of inadvertently leaving behind an abdominal mop or for that matter any Foreign body.

It is frustrating because you have no option but to accept the blame even though it may not have directly been your fault (an inefficient OT nurse or an assistant might have been the cause).The surgeon being the "captain of the ship" has invariably to bear the brunt of it all. It is also severely demoralizing because the fall-out may be horribly out of proportion to the magnitude of the error. In addition, the media love such errors as they provide juicy headlines and news - copy and as a result, retained Mops and other foreign bodies get the biggest headlines. Finally, almost always, there are very few credible defenses one can offer.

A retained surgical mop results in the formation of a gossypiboma. For a long time I thought it was called so because it invariably formed the subject of gossip in the surgeons' room! In fact, its origin is from the Latin 'gossypium' meaning 'cotton' and Swahili 'boma' meaning 'place of concealment' .Other words referring to this condition are 'textiloma', 'gauzoma'.

Legally, in the case of a retained mop, the theory of res ipsa loquitar can be invoked, viz ---"the facts speak for themselves" and the necessity to establish negligence is not considered necessary. In other words it may be considered negligence per se.

This being the case, you can well imagine the vital importance of trying to devise near fail-safe protocols for preventing such mishaps. The homily of better being safe than sorry, was never more appropriate.

I'd like to recount a few cases in which there is something to learn for all of us. These could have happened to any one of us but it is fervently hoped that the mere narration of these incidents will alert you and hopefully spare you any such ordeal in future.

1) A Gynecologist performed a hysterectomy in a case of endometriosis of the uterus and in the process, encountered several dense adhesions of the bowel loops. As it happened, the bowel got perforated in a place or two and a surgeon was invited to help. The surgery lasted a couple of hours and eventually the gynecologist completed the hysterectomy. The post-operative recovery was uneventful and everything seemed to be normal until a few months later when the patient started complaining

of intermittent abdominal pain. After poor response to symptomatic treatment, investigations such as x-ray abdomen,USG, etc. were carried out - but all of these were reported as normal. A diagnosis of post-op adhesions was made and laparoscopic adhesionolysis or laparotomy were the options suggested to the patient. However, the patient decided to change her doctor and landed up in another hospital where laparotomy was performed during which a retained mop was retrieved. The patient was informed of the same by the operating doctor and so was the local police. Later, the patient filed a complaint in the Consumer forum demanding compensation of nearly Rs. 3 lakhs from the Gynecologist as well as the Surgeon who assisted him.

On studying the details of the case a number of noteworthy points emerged :

i) USG examination and X-ray abdomen did not assist in early diagnosis. As it happened, the X-ray plates were seen by a couple of gynecologists, surgeons and radiologists. Sadly, everyone missed the radio-opaque thread on the X-ray, which, incidentally was seen rather prominently in the Consumer court!! It is not for nothing that it is said: "Hindsight is 60/60" Comment: It behooves all of us to actually see how the radio-opaque thread in the abdominal swab looks like on an X-ray. DO IT TODAY!

ii) The final outcome of the case was as follows : In view of the damning evidence, an out-of-court settlement was advised. The court approved of the same and Rs.1.75 lakhs was given to the patient. The legal document formalising the payment said this amount was paid "purely on humanitarian grounds for any inconvenience and suffering caused to the patient."

THE LEGALANGLE

Most of us do not know the exact legal position or the exact enormity of the act of leaving a mop in a body cavity, post-op. Is a retained FB an act of gross criminal negligence? Legally, the answer is NO. This is not my answer but the answer given by the Supreme Court of India by a 3-judge bench on 5th August 2005 in the case of Dr. Jacob Mathew Vs State of Punjab. This judgment should be read by all doctors so as to be well-equipped to defend themselves should the need arise. Stated simply and cutting aside the legal jargon, the judgment essentially states the following :

It divides negligence into 2 type's viz: Simple and Gross.

* Simple negligence involves merely lack of care, attention and skill. It is not criminal negligence. Mere inadvertence, lack of adequate care or attention or skill does not make a doctor criminally liable. This type of negligence will have a civil remedy and does not attract criminal liability.

* Gross negligence : The standard of negligence has to be so high as to be described as recklessness and has to be so grave as to show disregard for the life and safety of the patient and qualifies to a crime against the State. Gross negligence is a crime and actionable under the IPC.

Leaving a mop inside can certainly not be considered as gross negligence. It can be categorized as carelessness but not recklessness. It is a Civil wrong and would

hence come under the law of Torts. Monetary compensation or damages can be claimed against it after following the due process of law.

A significant comment by the 3-judge bench in the above judgment is worth reproducing and I quote: "No sensible professional would intentionally commit an act of omission which would result in loss or injury to the patient as the professional reputation of the doctor is at stake. A single failure may cost him dear in his career."

INCIDENCE

Overall, the retention of a foreign body is a rare event. In one American study the incidence was reported as 1 in 8801 in 18,760 inpatient operations at non-specialty acute care hospitals. The study concluded: "Our results suggest that, given the 28.4 million inpatient operations performed nationwide in 1999, more than 1500 cases of retained foreign body occur annually in the United States"

To determine the real incidence of retained mops and other FBs is difficult as many of them are not reported, understandably, for fear of legal reprisals.

RISK FACTORS

The following are the risk factors for post-op retained foreign body :

1. Change in nursing staff during surgery.
2. Excessive loss of blood.
3. Lack of complete count of sponges and instruments.
4. Fatigue in the surgical team due to lengthiness of the procedure.
5. Emergency nature of the surgery.
6. Obesity of the patient.
7. Unexpected intra-operative developments.
8. Involvement of a procedure with multiple surgical teams.
9. Performance of more than one major procedure at a time.

Foreign body retention is 9 times more likely when an operation is performed on an emergency basis and four times more likely when an operation involved an unexpected change in procedure.

PREVENTION

Finally, I'd like to highlight one important area which hitherto has been given the go-by but could go a long way in preventing retention of instruments in unintended places. I carried out a quick survey amongst surgeons and gynecologists about their OT protocol for preventing such eventualities. The majority of surgeons said they had a system of keeping a swab count during abdominal surgery. All relied on the final swab count of the assisting nurse. Many even maintained a blackboard or whiteboard on the wall to record the count and some had hooks displaying the swabs at the end of the surgery. However, not surprisingly, not even a SINGLE colleague said he or she maintained an instrument count.

Use of new technology :

Gauze sponges will be embedded with radiofrequency identification (rfid) tags as a result of which automated sponge count can be obtained with a hand-held device (like bar-code reader). Human error could be eliminated.

HOW SHOULD THE SURGEON WHO

REMOVES THE FB DEAL WITH THE SITUATION?

I must recount 3 cases of which I have personal, first-hand knowledge.

I) Post-open-cholecystectomy, a female patient developed intermittent abdominal pain and distension a few months after surgery.USG ordered by the surgeon did not reveal any abnormality. However, since the symptoms continued unabated, the patient consulted another surgeon who advised a CT scan. The report indicated a retained mop. Post-Laprotomy, the (second) surgeon not only prominently displayed the mop in front of all the relatives quite triumphantly but also handed them a copy of the recorded CD of the video-taped proceedings of the surgery. Expectedly, the relatives marched to the original surgeon, waving the CD in the air belligerently and demanded Rs 20 lakhs as compensation. The surgeon had no option but to negotiate a settlement.

ii) In the second case, a mop was removed by a Gynecologist in a case of C-section done in another nursing home. Post-surgery, the Gynecologist was pleased to have Zee (Hindi) TV journalists photograph the mop and interview the patient as well as herself. The news was telecast at least 10 times during the day. The headline of the news was "Doctor ne mahila ke pet men toulia chod diya. The sub-heading was "Ab wo maa kabhi bhi nahi ban sake gi" (Incidentally the patient conceived again in 5 months!) The first Gynecologist had to go through a nightmare. MMC took suo moto action by issuing the doctor a show cause notice (on the basis of Press reports) She had to face a criminal case as well as a Consumer Forum complaint.

iii) In the third case, a Gynecologist removed a mop from a patient who had undergone hysterectomy by another doctor. On removal, the mop was put in a fancy glass jar and given to the relatives but not before taking credit for having saved the patient's life! In this case, the repercussions were far more serious. The relatives went to the first Gynecologists clinic along with goons of a political party and brutally beat up the lady doctor and her husband, who was a non-gynec.

The above cases have been narrated to emphasize how the surgeon who removes the Mop should NOT behave.

THE RIGHT APPROACH

This is a rather crucial aspect of retained FBs which needs to be elaborated viz. the impact of the conduct of the surgeon who removes the FB (if he is not the surgeon who originally left the FB in the first place). There could be varying opinions on how the second surgeon must deal with the situation. My personal opinion is somewhat like this :

* The second surgeon must definitely document the findings related to the FB in the case record.
* The original surgeon should, as a matter of courtesy, be intimated about the findings, before the proposed second surgery, and could even be invited to be present at the operation.
* The relatives and the patient must be informed of the findings.
* However, while informing the relatives and patient, please remember--- how you say something is as important, if not more

important, as what you say. Do not dramatize the situation and make it look like you have performed some heroic, life-saving surgery. Do not display the FB triumphantly and imagine it to be some kind of a hunting trophy .Your body language and non-verbal communication should not indicate vicarious pleasure. Explain the retained FB with clinical precision and do not make it appear as if some criminal act has been committed. In fact, it should be stressed that it could happen to anyone...It is useful to remember that you can never say with finality "This can never happen to me ".

* Hence, if and when you find a retained FB……. DO document it; DO inform the patient and relatives. But do it in a manner you would like it to be done if you happened to be at the receiving end.

TO SUMMARISE

* Develop a rigid protocol for sponges, swabs and instruments.
* Use sponges, gauze pieces, etc having radio-opaque markers.
* Be extra-alert when the surgery involves the risk factors as listed above.
* Limit distractions, interruptions, conversation and unnecessary traffic in the OT. These increase chances of retained FB.
* The ultimate aim is to achieve zero error and total patient safety.
* Do not provoke patient and relatives against the earlier surgeon, even if he is not your best friend! Do unto others as you would have others Do unto you (Bible) !!
* More often than not, it is judicious to settle such cases without having to go to court.

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